		FOR OHF USE					

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0006353

Facility Name: Apostolic Christian Skylines

Address: 7023 NE Skyline Drive (Number) Peoria (City) 61614 (Zip Code)

County: Peoria

Telephone Number: (309) 691-8091 **Fax #** (309) 685-2505

IDPA ID Number: 370716056002

Date of Initial License for Current Owners: 08/12/1966

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[X]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Dave Blunier **Telephone Number:** (309) 691-8091

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2001 to 12/31/2001 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ February 22, 2002 (Date)
(Type or Print Name) Roger D. Herman
(Title) Administrator

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	14	Skilled (SNF)	14	5,110	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	43	Intermediate (ICF)	43	15,695	3
4	0	Intermediate/DD	0	0	4
5	29	Sheltered Care (SC)	29	10,585	5
6	0	ICF/DD 16 or Less	0	0	6
7	86	TOTALS	86	31,390	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,039	2,841	651	4,531	8
9	SNF/PED	0	0	0	0	9
10	ICF	3,153	11,719	0	14,872	10
11	ICF/DD	0	0	0	0	11
12	SC	784	7,002	0	7,786	12
13	DD 16 OR LESS	0	0	0	0	13
14	TOTALS	4,976	21,562	651	27,189	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.62%

D. How many bed-hold days during this year were paid by Public Aid?
12 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals, Housekeeping, Groundskeeping, Outpatient Therapy

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 08/12/1966

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 14 and days of care provided 651

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 2001 Fiscal Year: 2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	201,888	15,596	3,119	220,603	(10,525)	210,078	(13,476)	196,602			1
2	Food Purchase		154,246		154,246	(10,525)	143,721	(7,292)	136,429			2
3	Housekeeping	73,261	21,424		94,685		94,685	(3,014)	91,671			3
4	Laundry	38,206	5,763		43,969		43,969		43,969			4
5	Heat and Other Utilities			99,598	99,598		99,598	(19,920)	79,678			5
6	Maintenance	97,457	36,772	16,173	150,402		150,402	(39,392)	111,010			6
7	Other (specify):* (A)			5,225	5,225		5,225	(523)	4,702			7
8	**TOTAL General Services**	410,812	233,801	124,115	768,728	(21,050)	747,678	(83,617)	664,061			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,365,580	256,982	1,075	1,623,637		1,623,637	(4,265)	1,619,372			10
10a	Therapy	18,462		56,416	74,878		74,878		74,878			10a
11	Activities	99,328	3,580	263	103,171		103,171	(3,578)	99,593			11
12	Social Services	49,954		1,144	51,098		51,098	(1,499)	49,599			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,533,324	260,562	58,898	1,852,784		1,852,784	(9,342)	1,843,442			16
	C. General Administration											
17	Administrative	120,746			120,746		120,746	(5,899)	114,847			17
18	Directors Fees											18
19	Professional Services			9,256	9,256		9,256		9,256			19
20	Dues, Fees, Subscriptions & Promotions			10,935	10,935		10,935	(1,095)	9,840			20
21	Clerical & General Office Expenses	78,512	60,503		139,015		139,015	(15,128)	123,887			21
22	Employee Benefits & Payroll Taxes			489,268	489,268	21,050	510,318	(13,280)	497,038			22
23	Inservice Training & Education											23
24	Travel and Seminar			10,632	10,632		10,632		10,632			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			43,197	43,197		43,197	(4,320)	38,877			26
27	Other (specify):*											27
28	**TOTAL General Administration**	199,258	60,503	563,288	823,049	21,050	844,099	(39,722)	804,377			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,143,394	554,866	746,301	3,444,561		3,444,561	(132,681)	3,311,880			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Apostolic Christian Skylines #0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			223,307	223,307		223,307	(88,975)	134,332			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,400	2,400		2,400	(2,400)				32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):* **(B)**			6,262	6,262		6,262		6,262			36
37	**TOTAL Ownership**			231,969	231,969		231,969	(91,375)	140,594			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			11,669	11,669		11,669		11,669			40
41	Coffee and Gift Shops		5,885		5,885		5,885		5,885			41
42	Provider Participation Fee			31,207	31,207		31,207		31,207			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		5,885	42,876	48,761		48,761		48,761			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,143,394	560,751	1,021,146	3,725,291		3,725,291	(224,056)	3,501,235			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(14,584)	1,2		4
5	Telephone, TV & Radio in Resident Rooms	(11,517)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(88,975)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(26)	21		13
14	Non-Care Related Interest	(2,400)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,095)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(117,700)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (236,297)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (236,297)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Apostolic Christian Skylines

ID# 0006353

Report Period Beginning: 01/01/2001

Ending: 12/31/2001

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-Care Housekeeping	$ (84)	3	1
2	Non-Care Heat & Other Utilities	(19,920)	5	2
3	Non-Care Maintenance	(9,686)	6	3
4	Non-Care Security & Disposal	(523)	7	4
5	Non-Care Insurance	(4,320)	26	5
6	Non-Care Benefits and Payroll Taxes	(13,280)	22	6
7	Non-Care Dietary Wages	(6,184)	1	7
8	Non-Care Housekeeping Wages	(2,930)	3	8
9	Non-Care Maintenance Wages	(29,706)	6	9
10	Non-Care Nursing Wages	(4,265)	10	10
11	Non-Care Activity Wages	(3,578)	11	11
12	Non-Care Social Service Wages	(1,499)	12	12
13	Non-Care Administrative Wages	(5,899)	17	13
14	Non-Care Clerical Wages	(3,585)	21	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(105,459)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Apostolic Christian Skylines # 0006353 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(13,476)	0	0	0	0	0	0	0	0	0	0	(13,476)	1
2	Food Purchase	(7,292)	0	0	0	0	0	0	0	0	0	0	(7,292)	2
3	Housekeeping	(3,014)	0	0	0	0	0	0	0	0	0	0	(3,014)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(19,920)	0	0	0	0	0	0	0	0	0	0	(19,920)	5
6	Maintenance	(39,392)	0	0	0	0	0	0	0	0	0	0	(39,392)	6
7	Other (specify):*	(523)	0	0	0	0	0	0	0	0	0	0	(523)	7
8	**TOTAL General Services**	(83,617)	0	0	0	0	0	0	0	0	0	0	(83,617)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(4,265)	0	0	0	0	0	0	0	0	0	0	(4,265)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(3,578)	0	0	0	0	0	0	0	0	0	0	(3,578)	11
12	Social Services	(1,499)	0	0	0	0	0	0	0	0	0	0	(1,499)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(9,342)	0	0	0	0	0	0	0	0	0	0	(9,342)	16
	C. General Administration													
17	Administrative	(5,899)	0	0	0	0	0	0	0	0	0	0	(5,899)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(1,095)	0	0	0	0	0	0	0	0	0	0	(1,095)	20
21	Clerical & General Office Expenses	(15,128)	0	0	0	0	0	0	0	0	0	0	(15,128)	21
22	Employee Benefits & Payroll Taxes	(13,280)	0	0	0	0	0	0	0	0	0	0	(13,280)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(4,320)	0	0	0	0	0	0	0	0	0	0	(4,320)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(39,722)	0	0	0	0	0	0	0	0	0	0	(39,722)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(132,681)	0	0	0	0	0	0	0	0	0	0	(132,681)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Apostolic Christian Skylines # 0006353 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	(88,975)	0	0	0	0	0	0	0	0	0	0	(88,975)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,400)	0	0	0	0	0	0	0	0	0	0	(2,400)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(91,375)	0	0	0	0	0	0	0	0	0	0	(91,375)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(224,056)	0	0	0	0	0	0	0	0	0	0	(224,056)	45

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
NONE						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	NONE								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 2/31/2001

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Apostolic Christian Skylines **#** 0006353 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 20□0 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Apostolic Christian Skyline[illegible] COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0006353

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200(

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill whic is normally paid during 2001.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 57,100 B. General Construction Type: Exterior Brick Frame Steel / Masonary Number of Stories 2

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

Storage and Maintenance 4,650 Sq. Ft.
Apartment Complex 18,850 Sq. Ft. 18 Units
Duplexes 1,150 Sq. Ft./Unit 14 Units

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	200,000	1964	$ 743	1
2					2
3	TOTALS	200,000		$ 743	3

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	32		1966	1965	$ 348,310	$ (1,459)	50	$ 6,966	$ 8,425	$ 250,783	4
5	21		1971	1971	396,963	(11,358)	50	7,939	19,297	246,117	5
6	16		1985	1985	750,000	22,500	50	15,000	(7,500)	255,000	6
7	3		1989	1988	205,070	4,412	50	4,101	(311)	53,318	7
8			1995	1995	870,388	17,406	50	17,407	1	121,854	8
	Improvement Type**										
9	17 Bed Addition acquried in 1996			1996	793,538	15,871	50	15,871		95,226	9
10	Sheltered Care Remodeling			1974	6,594	899	42	157	(742)	4,396	10
11	Fire Prevention System			1977	23,804	1,253	44	541	(712)	13,525	11
12	Dining Room Addition			1978	38,922	7,058	38	1,024	(6,034)	24,582	12
13	Fire Prevention System			1979	35,330	6,624	37	955	(5,669)	21,962	13
14	Window Replacements			1981	23,820	4,877	35	681	(4,196)	14,292	14
15	Kitchen Remodeling			1982	21,631	4,600	34	636	(3,964)	12,724	15
16	Energy Conservation, Cabinets, Water Heater, Emerg. Power			1983	8,413	1,988	33	255	(1,733)	4,844	16
17	Sheltered Care Remodeling			1984	7,742	1,720	32	242	(1,478)	4,355	17
18	Cabinets			1986	1,618	383	30	54	(329)	863	18
19	Air Conditioning			1987	6,427	2,727	29	222	(2,505)	3,324	19
20	Physical Therapy Room			1989	11,503	2,806	27	426	(2,380)	5,538	20
21	Office Addition			1991	50,297	12,999	25	2,012	(10,987)	22,131	21
22	New Roof			1993	14,210	3,288	23	618	(2,670)	5,560	22
23	Room Remodeling			1994	5,154	1,153	22	234	(919)	1,874	23
24	Front Enterance Canopy, Front Office, Ceiling Back Hall			1996	62,294	11,584	20	3,115	(8,469)	18,688	24
25	Gutters, Downspouts, and Facia, Remodel 1971			1996	89,096	12,473	25	3,564	(8,909)	21,383	25
26	Fence, Front Soffit & Facia Auto Front Door			1997	28,036	3,458	24	1,168	(2,290)	5,841	26
27	New Floor Coverings, Light Fixtures, Paint, Wallpaper, Etc			1998	88,061	10,056	23	3,829	(6,227)	15,315	27
28	Door and Fire Alarms			2000	4,978	202	33	151	(51)	302	28
29	New Floor Coverings, Light Fixtures, Paint, Wallpaper, Etc			2000	110,832	4,500	33	3,359	(1,141)	6,717	29
30	New Floor Coverings, Paing, Wallpaper, Bookcases			2001	42,939	1,342	32	1,342		1,342	30
31	New Lobby Window			2001	3,577	238	15	238		238	31
32	New Air Conditioner in 1989 Addition			2001	2,178	57	38	57		57	32
33	Blacktopping Parking Lot			2001	13,967	436	32	436		436	33
34	Balcony Repair			2001	10,887	726	15	726		726	34
35	Insulation			2001	9,970	312	32	312		312	35
36	Lawn Sprinkler System			2001	9,650	302	32	302		302	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 4,096,199	$ 145,433		$ 93,940	$ (51,493)	$ 1,233,927	70

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 614,534	$ 30,727	$ 30,727	$	20	$ 184,336	71
72	Current Year Purchases	70,901	3,545	3,545			3,545	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 685,435	$ 34,272	$ 34,272	$		$ 187,881	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Maintenance	1979 John Deere Tractor	1979	$ 4,400	$	$ 220	$ 220		$ 4,040	76
77	Resident Transportation	1999 Ford Bus	1999	58,988		5,899	5,899		12,220	77
78										78
79										79
80	TOTALS			$ 63,388	$	$ 6,119	$ 6,119		$ 16,260	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,845,765	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 179,705	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 134,331	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (45,374)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,438,068	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Non-Care Building Projects	$ 1,380,760	$ 38,972	$ 575,587	86
87	Non-Care Equipment	55,860	4,629	16,577	87
88	Non-Care Vehicles	28,450		12,360	88
89	Non-Care Land	112,446			89
90					90
91	TOTALS	$ 1,577,516	$ 43,601	$ 604,524	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

   Hired only Aides who were already trained

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a-3	hrs	$	103	$ 6,454	$	103	$ 6,454	1
2	Licensed Speech and Language Development Therapist	10a-3	hrs		52	3,329		52	3,329	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a-3	hrs		109	7,497		109	7,497	4
5	Physician Care		visits							5
6	Dental Care	10	visits		8	1,310		8	1,310	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	10	# of prescrpts				163,182		163,182	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$	272	$ 18,590	$ 163,182	272	$ 181,772	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2001 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 10,195	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	314,599		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	27,041		5
6	Prepaid Insurance	31,341		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 383,176	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	1,263,249		12
13	Land	113,189		13
14	Buildings, at Historical Cost	5,476,959		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	833,133		16
17	Accumulated Depreciation (book methods)	(2,042,593)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	130,612		21
22	Other Long-Term Assets (specify):	18,787		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 5,793,336	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,176,512	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 42,392	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	56,757		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Earned Time Off Payable	42,903		36
37	Misc. Employee Deductions Payable	4,144		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 146,196	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Contingent Payable	130,612		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 130,612	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 276,808	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,899,704	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,176,512	$	48

***(See instructions.)**

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,841,336	1
2	Restatements (describe):		2
3	**Adjustments made to asset accounts**	15,634	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,856,970	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	42,734	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 42,734	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,899,704	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,944,750	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,944,750	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	90,501	6
7	Oxygen	12,232	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 102,733	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	6,767	12
13	Barber and Beauty Care	11,052	13
14	Non-Patient Meals	25,247	14
15	Telephone, Television and Radio	11,517	15
16	Rental of Facility Space		16
17	Sale of Drugs	162,949	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,932	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry	84	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 221,548	23
	D. Non-Operating Revenue		
24	Contributions	443,535	24
25	Interest and Other Investment Income***	55,459	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 498,994	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 3,768,025	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	768,728	31
32	Health Care	1,852,784	32
33	General Administration	823,049	33
	B. Capital Expense		
34	Ownership	231,969	34
	C. Ancillary Expense		
35	Special Cost Centers	17,554	35
36	Provider Participation Fee	31,207	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,725,291	40
41	**Income before Income Taxes (line 30 minus line 40)****	42,734	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 42,734	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,894	2,069	$ 48,261	$ 23.33	1
2	Assistant Director of Nursing	1,969	2,069	43,973	21.25	2
3	Registered Nurses	18,322	19,268	345,983	17.96	3
4	Licensed Practical Nurses	11,288	12,014	190,462	15.85	4
5	Nurse Aides & Orderlies	66,144	69,695	713,977	10.24	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,526	1,526	18,462	12.10	8
9	Activity Director	3,314	3,621	38,341	10.59	9
10	Activity Assistants	6,848	7,254	57,409	7.91	10
11	Social Service Workers	2,995	3,228	48,456	15.01	11
12	Dietician					12
13	Food Service Supervisor	1,915	1,915	24,654	12.87	13
14	Head Cook	2,198	2,334	22,683	9.72	14
15	Cook Helpers/Assistants	15,734	16,432	141,206	8.59	15
16	Dishwashers	950	1,000	7,162	7.16	16
17	Maintenance Workers	5,632	6,055	67,752	11.19	17
18	Housekeepers	8,190	8,650	70,331	8.13	18
19	Laundry	4,886	5,203	38,206	7.34	19
20	Administrator	1,889	1,997	64,592	32.34	20
21	Assistant Administrator	1,864	1,955	50,255	25.71	21
22	Other Administrative					22
23	Office Manager	2,437	2,745	42,230	15.38	23
24	Clerical	3,604	3,723	32,697	8.78	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,243	2,307	18,656	8.09	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	165,842	175,060	$ 2,085,748 *	$ 11.91	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	125	$ 3,119	1-3	35
36	Medical Director				36
37	Medical Records Consultant	20	1,075	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	6	263	11-3	44
45	Social Service Consultant	32	1,144	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	183	$ 5,601		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Roger D Herman	Administrator	0	$ 67,283
Richard L Plattner	Asst. Administrator	0	53,463
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 120,746

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Apostolic Christian Restmor	Accounting	$ 1,449
Westervelt Johnson	Legal	1,714
Wellspring Program		6,093
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 9,256

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,786
Unemployment Compensation Insurance	8,459
FICA Taxes	165,788
Employee Health Insurance	170,563
Employee Meals	21,050
Illinois Municipal Retirement Fund (IMRF)*	
401K Retirement Plan	50,859
Physicals	5,099
Incentives	33,849
Scholarship	8,865
Non-Care Incentives and Taxes	(13,280)
TOTAL (agree to Schedule V, line 22, col.8)	$ 497,038

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	3,196
Health Care Worker Background Check	434
(Indicate # of checks performed 31)	
Trade Organizations	4,282
Publications for Resident Areas	651
Trade Publications	1,277
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,840

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 968
In-State Travel	2,484
Seminar Expense	7,180
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,632

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Apostolic Christian Skylines # 0006353 Report Period Beginning: 01/01/2001 Ending: 12/31/2001

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Apostolic Christian Skylines # 0006353 **Report Period Beginning:** 01/01/2001 **Ending:** 12/31/2001

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LSN = 3091; ALFA = 135; AAHSA = 1056**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **20**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **22,514** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **31,207**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classifiec
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **21,050** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **7,017**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes - those that are care related**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Apostolic Christian Skylines
2001 Employee Seminar Expense

Employee	Title	Seminar	Dates	Place	Sponsor	Cost	Travel
Cooley, Jacqueline	MDS Coordinator	Adult CPR Class	1/29/2001	Peoria, IL	American Red Cross	20.00	
Krans, Susan	RN	Adult CPR Class	1/29/2001	Peoria, IL	American Red Cross	20.00	
Streitmatter, Cheri	RN	Adult CPR Class	1/29/2001	Peoria, IL	American Red Cross	20.00	
Lindbom, Deborah	RN	Adult CPR Class	1/29/2001	Peoria, IL	American Red Cross	20.00	
Wilson, Virginia	LPN	Adult CPR Class	1/29/2001	Peoria, IL	American Red Cross	20.00	
Streitmatter, Naomi	RN	Adult CPR Class	1/29/2001	Peoria, IL	American Red Cross	20.00	
Vyverberg, Mari	ADON	Adult CPR Class	1/29/2001	Peoria, IL	American Red Cross	20.00	
Reith, Irma	RN	Adult CPR Class	1/29/2001	Peoria, IL	American Red Cross	20.00	
Price, Patricia	LPN	Adult CPR Class	1/22/2001	Peoria, IL	American Red Cross	20.00	
Lister, Joy	RN	Adult CPR Class	1/22/2001	Peoria, IL	American Red Cross	20.00	
Ringenberg, Nanette	RN	Adult CPR Class	1/22/2001	Peoria, IL	American Red Cross	20.00	
Dalton, Karin	RN	Adult CPR Class	1/22/2001	Peoria, IL	American Red Cross	20.00	
Young, Brenda	RN	Adult CPR Class	1/22/2001	Peoria, IL	American Red Cross	20.00	
Spencer, Trudy	DON	Adult CPR Class	1/22/2001	Peoria, IL	American Red Cross	20.00	
Berry, Debra	RN	Adult CPR Class	1/22/2001	Peoria, IL	American Red Cross	20.00	
Tun, Indara	RN	Adult CPR Class	1/22/2001	Peoria, IL	American Red Cross	20.00	
Tatum, Linda	RN	Adult CPR Class	1/22/2001	Peoria, IL	American Red Cross	20.00	
Pierce, Marie	Activity Director	10th Annual Alzheimer's Disease Conference	3/29/2001	Peoria, IL	Alzheimer's Association	55.00	
Wilson, Virginia	LPN	10th Annual Alzheimer's Disease Conference	3/29/2001	Peoria, IL	Alzheimer's Association	55.00	
Tatum, Linda	RN	10th Annual Alzheimer's Disease Conference	3/29/2001	Peoria, IL	Alzheimer's Association	55.00	
klopfenstein, Kathleen	Social Services	10th Annual Alzheimer's Disease Conference	3/29/2001	Peoria, IL	Alzheimer's Association	55.00	
Spencer, Trudy	DON	10th Annual Alzheimer's Disease Conference	3/29/2001	Peoria, IL	Alzheimer's Association	55.00	
Thompson, Kelly	CNA	10th Annual Alzheimer's Disease Conference	3/29/2001	Peoria, IL	Alzheimer's Association	55.00	
Freeman, Sheila	CNA	10th Annual Alzheimer's Disease Conference	3/29/2001	Peoria, IL	Alzheimer's Association	55.00	
Price, Patricia	RN	10th Annual Alzheimer's Disease Conference	3/29/2001	Peoria, IL	Alzheimer's Association	55.00	
Krans, Susan	RN	10th Annual Alzheimer's Disease Conference	3/29/2001	Peoria, IL	Alzheimer's Association	55.00	
McFarlane, Margaret	Activity Director	IAPA Convention	10/6/2001	Decatur, IL	IAPA	205.00	167.20
McFarlane, Margaret	Activity Director	IOC Review	11/17/2001	Galesburg, IL	Rick J Ramirez	60.00	
Milleville, Margaret	Activity Assistant	IOC Review	11/17/2001	Galesburg, IL	Rick J Ramirez	60.00	
Herman, Roger	Administrator	AAHSA Convention	11/03/2001-11/08/2001	San Diego, CA	AAHSA	620.00	322.50
Lehman, Rebecca	Dietary Supervisor	Being an Effective Team Leader	9/21/2001	Peoria, IL	Employers Assoc. of IL	240.00	
Prescott, Yvette	Dietary Supervisor	Being an Effective Team Leader	9/21/2001	Peoria, IL	Employers Assoc. of IL	240.00	
Davis, Renee	Social Services	Addressing Mental Health Issues in Elderly	10/8/2001	Peoria, IL	Mental Health Assoc.	80.00	
Vyverberg, Mari	Social Services	Addressing Mental Health Issues in Elderly	10/8/2001	Peoria, IL	Mental Health Assoc.	80.00	
Blunier, Dave	Accountant	Achieve Users Group Meeting	11/8/2001	Bloomington, IL	Acheive Heathcare Inf. Systems	15.00	39.57
Herman, Roger	Administrator	LSNI Convention	04/24/01-04/27/01	Chicago, IL	LSN	395.00	900.00
Herman, Roger	Administrator		9/1/2001		LSN	145.00	
Plattner, Richard	Asst. Admin.	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	48.25
Plattner, Richard	Asst. Admin.	AAHSA Convention	11/03/2001-11/08/2001	San Diego, CA	AAHSA	620.00	645.00
Blunier, Dave	Accountant	Medicaid Reimbursement	6/27/2001	Morton, IL	LSN	45.00	
Cooley, Jacqueline	MDS Coordinator	LSNI Convention	04/24/01-04/27/01	Chicago, IL	LSN	395.00	
Klopfenstein, Kathleen	Social Services	LSNI Convention	04/24/01-04/27/01	Chicago, IL	LSN	395.00	
Plattner, Richard	Asst. Admin.	LSNI Convention	04/24/01-04/27/01	Chicago, IL	LSN	395.00	875.56
Klopfenstein, Kathleen	Social Services	Eldercare: Challenges and Opportunities	10/3/2001	Peoria, IL	Methodist Medical Center	70.00	
Cooley, Jacqueline	MDS Coordinator	Eldercare: Challenges and Opportunities	10/3/2001	Peoria, IL	Methodist Medical Center	70.00	
McFarlane, Margaret	Activity Director	Developing Cultural Sensitivity	9/20/2001	Eureka, IL	Maple Lawn Homes	30.00	
Herman, Roger	Administrator	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	
Spencer, Trudy	DON	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	4.50
Vyverberg, Mari	ADON	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	
Bierly, David	Dietary Supervisor	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	15.54
Lane, Dan	Environmental Services	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	
Davis, Renee	Social Services	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	12.78
Klopfenstein, Kathleen	Social Services	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	14.52
McFarlane, Margaret	Activity Director	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	
Cooley, Jacqueline	MDS Coordinator	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	
Blunier, Dave	Accountant	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	
Streitmatter, Naomi	Nurse	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	
Post, Wanda	Activity Assistant	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	
Milleville, Margaret	Activity Assistant	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	
Tun, Indara	Nurse	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	
Streitmatter, Cheri	Nurse	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	
Wilson, Virginia	Nurse	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	
Tatum, Linda	Nurse	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	
Pierce, Marie	Activity Director	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	
Lehman, Rebecca	Dietary Supervisor	IHCA Conference	09/10/01-09/12/01	Peoria, IL	IHCA	36.25	
Kalb-Deemie, Clara	CNA	Physical Rehab Aide Training	06/5/01-06/12/01	Peoria, IL	PTS	205.00	
Mabberly, Rachel	CNA	Physical Rehab Aide Training	06/5/01-06/12/01	Peoria, IL	PTS	205.00	
Tun, Indara	Nurse	Wellspring Coordinator Meeting	7/17/2001				33.10
McFarlane, Margaret	Activity Director	Assessment and Treatment of Depression	8/31/2001	Galesburg, IL	Rick J Ramirez	75.00	33.47
Cooley, Jacqueline	MDS Coordinator	Assessment and Treatment of Depression	8/31/2001	Galesburg, IL	Rick J Ramirez	75.00	
McFarlane, Margaret	Activity Director		4/4/2001	Springfield, IL	Rick J Ramirez		51.06
Cooley, Jacqueline	MDS Coordinator	Medical Records Solutions	6/26/2001	Galesburg, IL	Creative Solutions		31.74
Blunier, Dave	Accountant	Medicare	3/14/2001	Peoria, IL	Administar		8.33
Housekeepers	Environmental Services	PMI Training	5/31/2001	Peoria, IL	PM of Illinois	900.00	
Blunier, Dave	Accountant	MEDA Training	6/19/2001	Chicago, IL	Administar		249.07
						7,180.00	
							3,452.19
						$	*10,632.19*